

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-013902

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

318 1003 3278
FILED MAR 28 1963

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO. b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS MO.		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION ST. LOUIS CITY HOSP. # 1		d. STREET ADDRESS 508 CHESTNUT	
3. NAME OF DECEASED (Type or print) WILLIAM TAGLOWSKI		4. DATE OF DEATH FEB. 21 63	
5. SEX MALE	6. COLOR OR RACE WHITE	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 12-17-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NO		10b. KIND OF BUSINESS OR INDUSTRY NONE	
13a. FATHER'S NAME PAUL TAGLOWSKI		13b. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, or unknown) (If yes, give war or dates of) NO		16. SOCIAL SECURITY NO. 0022	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infection Chronic Lung disease Due to (b) old Tuberculosis Due to (c)		17. INFORMANT ST. LOUIS CITY HOSP. #1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2/19/63 to 2/21/63 and last saw her alive on 2/21/63		Death occurred at 6:15 P. M. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE Thomas J. Ridgen M.D.	22b. ADDRESS 1515 LAFAYETTE AVE		22c. DATE SIGNED 2/21/63
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE 3-31-63	23c. NAME OF CEMETERY OR CREMATORY Anatomical Board	23d. LOCATION (City, town, or county) (State) St. Louis, Mo.
24. FUNERAL DIRECTOR Howard Aker Mortuary Service 4104 Manchester Ave. St. Louis 10, Mo.		25. DATE RECD. BY LOCAL REG. MAR 21 1963	
		26. REGISTRAR'S SIGNATURE Earl Smith, M.D.	

USE BLACK INK
OR
TYPEWRITER RIBBON

Ridgen

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P.O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.